A SYNOPSIS OF THE POPOSED P.HD THESIS ENTITLED

AN EVALUATORY STUDY ON FINANCIAL ASSITANCE & CLAIM SETTELMENTS UNDER RAJIV GANDHI JEEVANDAYEE AAROGYA YOJANA IN NANDED DISTRICT

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Introduction:

Families living the below poverty line are drawn into a various cycle of health problems, poverty, bankruptcy and indebtedness (NRHM. 2005). When faced with serious ailments they often need to borrow large sums and have to sell their assets to meet the costs of treatment and hospitalisation. The experience of below poverty line (BPL) families in Maharashtra (MH) is not dissimilar. Many people faced with such a situation have been approaching the government of Maharashtra for financial assistance to meet the costs of hospitalisation. As of now, millions of rupees have been distributed from the state's Chief Minister's Relief Fund (CMRF) in order to provide financial assistance to the beneficiaries to meet their hospital expenses. Thus, there was a felt need by the Maharashtra Government to assist BPL and APL families to meet treatment and care costs related to serious illness. The Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY) was conceptualised as a Jeevandayee Aarogya Yojana that would address this need in Maharashtra state so that BPL families across the state could be benefited from it.

Four years back Maharashtra Government (MH) has started different requirement side innovative and creative ideas for helping the poorest of the poor family in the state and spending huge amount on health issues increasing inequity between poor families. Some of the big health insurance schemes in innovative has been implemented and practiced for BPL families. To provide cashless transaction of providing health insurance facilities is current scenario of Maharashtra governments, its schemes implemented for social, and community based schemes for health insurance. Moreover, these schemes are having targeted basis

approach and have less covering that every time removes various poorest section. All the health insurance scheme that is exists were getting very poor responses in health benefits and we can say health outcomes.

Medical care is more costly for below poverty line families. Correspondingly, those in conditions for requiring specialised consultative care very often not being treated or went with excessing hospital bill, both of above aggravate poverty. Furthermore, the burden of ischemic heart disease and cancer diseases that can possibly be dealt with specialist consultant as tertiary care is rising in many countries with huge poverty such as India, China and Bangladesh. To improve the need for tertiary care while giving financial health security to the families with low incomes, various states in India have raised social health insurance programs that contribute free tertiary care to families with below and above the poverty line. These insurance sc hemes are sponsored through tax and commonly do not necessitate premiums or fees from households.

Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY) have launched for this purpose on 2nd July 2012 in Maharashtra, a state with over 50 lakh families (8 district in Phase-I) and near about 2 cores of beneficiaries of Maharashtra states. Rajiv Gandhi is the name of a former Indian prime minister, and Jeevandayee Aarogya means "Life care." The scheme allow eligible participants to free care for a selected s peciality and procedures of tertiary care services and the most common diseases are trauma care, cardiac, oncologic, nephrology, urology, neurology and burn. Same like any other health insurance schemes, Rajiv Gandhi Jeevandayee Aarogya Yojana has implemented to improve the health care of BPL & APL families to use of services for the use of healthcare necessities for reducing frequently miserable expenditure costs related to complicated diseases. Dissimilar India's national health insurance scheme for below poverty line, families while doing the study

(RSBY - Rashtriya Swasthya Bima Yojana), nevertheless, the Rajiv Gandhi Jeevandayee Aarogya Yojana covers maximum speciality and procedures with tertiary care and it does not require annual premiums for below and above poverty line families. This scheme also encourage network hospitals to treat the patients with oncology & cardiac case for whom urgently requires expensive medical care and treatment. Researcher assessed scope through which the scheme guides low-income families' for changes in the health insurance results and usage among its purposive beneficiary families.

In the Published reviews, it implicates that at the time of insurance improves usage and reduces personal cost. There is very less proofs on the influence of health insurance on the health and financial good health of beneficiaries in developing countries. The evidence on health usages is assorted. There is an evidence from Colombia says that, the speedy growth of health insurance in the 1990s show to a development in neonata health results. Research study in US and Thailand also provide evidence for feasible health benefits when the insurance scheme is well coordinate to the health issues and targeted beneficiaries' population. Furthermore, several researchers have found a mixed or invalid effect of insurance on health results. Consideration of irregular roll out of Mexico's Seguro famous, which offers exhaustive insurance coverage for below poverty line families that develop it declined unfortunate health expenses but had a mixed effect on fulfilment and health developments. Likewise, consideration of insurance and less premium schemes in Ghana and Burkina Faso found decrease in miserable health expenses without development in health results.

Outcomes of the schemes evaluated by researcher, acknowledge that its distinctive coverage characteristics a separate bunch of services that were selected for their accepted strength and capability, near match with excessive responsibilities, underutilised and objectives provided a

prospective convincing approach for encourage health developments with insurance. Researcher utilised the phased roll out of the scheme to describe its influence on utilisation, economical protection, and mortality. Originally, it provided insurance to households below and above the poverty line in two organisational divisions encompassing various districts in the northern part of Maharashtra state; In the month of July, 2012 scheme decided to spread insurance coverage to the below and above poverty line families in the whole state. During this surprise execution, researcher assesses the program's developments using a quasi-experimental design that capture well- being of the intense frontier in coverage. In specific, researcher differentiates outcomes in adjacent villages on either side of the borderline drawn between the groups selected for prior versus late execution.

There are different studies revealed that establish the absolute procedures and it gives comprehensive implementation of Rajiv Gandhi Jeevandayee Arogya Yojana required a various techniques or methods to documentation the losses, success & bottlenecks. By using both quantitative and qualitative techniques, data was captured to get the answers to the study objectives. Triangulation of the data was collected just for to understand theoretical issues of the scheme and to prepare restated recommendations for the policy.

Review of Literature:

According to Barro and Sala-i-Martin the role of health in affecting economic development has been well believed at the micro level. It has been documents that good health also has a favourable effect on the learning abilities of children, and leads to better educational 47 outcomes (school completion rates, higher mean years of schooling, achievements) and increases the effectiveness of human capital formation by individuals

and households. Healthful employees are possibly to be able to work for long time, be normally more fruitful than their comparatively less healthy opposite.

Gupta and Mitra (2003) have studied the connection between poverty, health and economic development in India for the years 1973/74, 1977/78, 1983, 1987/88, 1993/94, 1999/2000 based on data for 15 Indian States. Their econometric research manifest that per capita public health expenses positively affects health status, that poor reduced with good health, and that improves and health have a positive two-way relationship. Bloom,

Sevilla and Canning (2004) Have studied that, as the Intra, country analysis has the benefit of being better provision to administer data comparability problems relating to health, education and economic performance, there are studies, which have been carried out in his direction. Having proofs from more than a dozen cross-country researches and all these researches, with a single exception, show that health has a positive and statistically important effect on the rate of development of GDP per capita.

Duraisamy & Mahal in 2005 was found and suggested that there is a two-way purpose between health status and financial development. The outcome of health constant by expectation of life is favourable and important on economic development even after managing for initial income levels. In addition, a thousand rupee increase in per-capita health expenses would lead to a 1.3 percent increase in LEB, while a 10 percent increase in per capita income is required to increase the LEB by about 2percent. Also there survey using a cross state panel dataset for 14 major Indian States for the year 1970/71, 1980/81, 1990/91 and 2000/01, comprising thirty year period. The health status of the community was recorded through two indicators – Life Expectancy at Birth (LEB) and Infant Mortality Rate

(IMR). Excluding health, human capital was measured along with two supplementary extents – average year of schooling and work experience.

According to **Thankappan's K.R** in 1999 that, the working procedure under the scheme and found that 9 hospitals in the district of Thiruvananthapuram in Kerala state that, the private sector have tendency to keep patients in their hospitals for a shorter time though he/she require more hospitalisation and order more investigation tests whereas in public sector hospitals it is very less.

In 2005 **Rao Sujata** has compele her attention to the health system in India consists of a public sector, a private sector and an informal network of providers of care operating within an uncontrollable situation, with no power on what services can be delivered by whom, in what manner, and at what cost, and no systematize etiquette to help control the quality of care. There is broad discrepancy in entry, furthermore intensify by the imperfect performance of the public health system.

Importance and rational of the Research Study:

Since last decade, In India centre & state government have been implemented a number of schemes for development of health care of poorer families who comes under the above poverty line and below poverty line, but not reaching to those who are actual beneficiary of this scheme. Some training and development Programmes are conceived as holistic Programmes to the below poverty line (BPL) family's health relates scheme knowledge concern.

This try to make awareness about health insurance through Rajiv Gandhi Jeevandayee Aarogya Yojana schemes among the below and above (BPL & APL) poverty line families and also creating awareness among below poverty line families from economical responsibilities arising out of health disturbance that require hospitalisation.

Maximum beneficiary families of this scheme were belongs to very poor family and living in remote areas with less or no access to medical care. Families who belongs to ineligible areas obtained "(BPL) below poverty line" card provided by the state government were automatically enrolled. This authorizes families to get free medical quality healthcare at both public and private network hospitals for providing services into the scheme as effective of providing quality healthcare. For the point of service, beneficiaries did not paid single rupees, premiums, or co-payments. As of Nov 2015, the RGJAY scheme has attached near about 500 hospitals efficient of providing quality healthcare, it includes all top hospitals in the state of Maharashtra. Service providers will get predefined package amount depending on a reimbursement procedure for more than 30 specialities and 971 procedure service packages in cardiology, nephrology, urology, neonatology, oncology, burn care, and trauma care etc. As majority of hospitals are in town or city centres in Maharashtra whereas beneficiaries are based in remote areas in villages that are far several kilometres away, every network hospitals were mandatory to conduct health camps in remote areas to screen patients for tertiary care and refer eligible patients to hospitals for further treatment and hospitalisation. It is mandatory for each network to conduct four health camps in every month and received a fixed payment for each health camps conducted by hospitals, because hospitals have signed an agreement to conduct four health camps in every month. Majority of rural patients receiving quality health care with the help of RGJAY scheme and the patient were screened in these health camps conducted by network hospitals.

In light of **an evaluatory study on financial assistant and claim settlements of Rajiv Gandhi Jeevandayee Aarogya Yojana** this is one of the first evaluatory studies to find out the changes or shift in the current parameter of segmentation in health care industries in a large research base. However few studies available in the form of research paper, article etc.

The study represents a satisfaction level of beneficiary and hospital under Rajiv Gandhi Jeevandayee Aarogya Yojana hence in view of this it felt necessary to the researcher to study covering wider area of the Nanded district in Maharashtra. Therefore, the title of my research study "A STUDY OF HEALTH CARE FINANCING FOR LOW INCOME FAMILIES THROUGH RAJIV GANDHI JEEVANDAYEE AROGYA YOJANA WITH REFERENCE TO NANDED DISTRICT".

Objectives of the Research

1. To examine the contribution of the scheme to achieving overall health improvement in Nanded district.
2. To examine the effective implementation of RGJAY in providing financial assistance to the beneficiaries.
3. To study two-way challenges faced by beneficiary in getting cashless services under RGJAY and Network hospital in reimbursing the claim against those cashless treatment given to RGJAY beneficiaries.
4. To measure the satisfaction level of beneficiaries under RGJAY.

Hypotheses of research study:

Null Hypothessis-1: There is no significant contribution of RGJAY scheme in achieving overall health improvements of beneficiaries.

Null Hypothesis-2: Govt. of Maharashtra has taken significant efforts in creating awareness among the beneficiaries under RGJAY.

Null Hypothesis-3: There is effective implementation of RGJAY in providing financial assistance to the beneficiaries.

Null Hypothesis-4: There is no significant satisfaction level of beneficiaries under RGJAY.

Research Methodology:

1. **Types of research design –** This is descriptive research for conducting the research work for the above title.
2. **Source of data collection –**

Primary data:- for this research work primary data will be collected by visiting beneficiaries in person scattered all over Nanded district of Maharashtra.

Secondary data: - To collect the information required for this study will be collected from various sources like District office, Project office, books, journals, research paper, research articles, reports of governments and newspapers and extensive use of related web sites of Rajiv Gandhi Jeevandayee Arogya Yojana.

3. **Research approach:** researcher will use the approach to collect necessary and first-hand information of the beneficiary for research study is purely based on survey method.
4. **Research Instrument:** to collect necessary and required information will be collected though designing questionnaires, scheduler method interview to make related inquires for research work.
5. **Types of questionnaire:** for this study structured and defined from questionnaire to collect the required information for study.
6. **Types of questions:** To make necessary inquiry for research work closed ended questionnaires are prepared by the researcher.
7. **Universe or population of study:** To conduct the research work the researcher has defined the universe Nanded district as whole.

8. **Sampling Plan:**

I. **Sampling Unit**: Beneficiaries who have taken benefits under the health insurance scheme Rajiv Gandhi Jeevandayee Arogya Yojana are the units for this research work.

II. **Sampling Size**: Researcher has selected 2014-15 year for study, Total 11883 beneficiaries were taken benefits under RGJAY during the period of 2nd July,2014 to 1st July, 2015 out of that Total numbers of respondents for research study are 400 beneficiaries scattered all talukas of Nanded district.

Sr.No	Name of Taluka	Name of Patient District	Beneficiaries
1	Ardhapur	NANDED	438
2	Bhokar	NANDED	493
3	Biloli	NANDED	607
4	Deglur	NANDED	668
5	Dharmabad	NANDED	333
6	Hadgaon	NANDED	1125
7	Himayatnagar	NANDED	377
8	Kandhar	NANDED	856
9	Kinwad	NANDED	605
10	Loha	NANDED	931
11	Mahoor	NANDED	235
12	Mudkhed	NANDED	401
13	Mukhed	NANDED	924
14	Naigaon	NANDED	583
15	Nanded	NANDED	2897
16	Umari	NANDED	410
Grand Total			**11883**

(Source: https://www.jeevandayee.gov.in/RGJAY/2014-15)

III. **Methods of Sampling**: As per research topic, researcher covers Rajiv Gandhi Jeevandayee Aarogya Yojana

beneficiaries of Nanded district including all Talukas of Nanded district, Because there has being limitation of time period. According to sampling techniques researcher has been used simple random sampling methods.

9. **Contact method:** to conduct the research work researcher will be visited in person to get necessary and required information for research work.

Limitations of the study:

1. The benefit of the scheme is restricted to the members whose name is there in the BPL and APL ration card only.
2. This scheme is having Sum insured amount of Rs.1.50 lakh per family per year on floater basis.
3. The beneficiaries are mandatory to get the advantage of the scheme only in Hospitals empanelled with the Scheme.
4. The beneficiaries are entitled for quality critical care of only predefined 30 specialties categorised into 972 procedures.

PROPOSED CHAPTER PLAN FOR RESEARCH STUDY

Chapter 1: Introduction
Chapter 2: Literature Review
Chapter 3: Profile of Nanded District
Chapter 4: Rajiv Gandhi Jeevandayee Aarogya Yojana: An Overview
Chapter 5: Data Analysis and Interpretation
Chapter 6: Conclusions and Suggestions

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